Introduction

How do you keep the Black female body present and how do you own value for something that society won’t give value to?
—Claudia Rankine (Cocozza 2015)

In 2008, Ashley Bey, a nineteen-year-old African American woman from Illinois, was a college student when she became pregnant and then delivered a little girl, Jamie, three months early. 1 We met after I gave a talk in 2014 at a university in Illinois about my research on neonatal intensive care units (NICUs). She brought both of her children, Jamie and Justin, to the talk. Jamie sat on the side of the room coloring while her mother rocked the carriage in which Justin was sleeping. An hour later, at the end of the talk, Ashley tremulously made her way to the front of the room where I was standing. I saw her from the corner of my eye, but I was engaged in conversation with some of the faculty who had attended. Ashley waited patiently. After I finished my conversation, I turned and gestured for her to come closer. She appeared uncomfortable, so I made small talk and chatted with her daughter, which seemed the best way to ease Ashley’s discomfort. After a while, there were only about two or three other people left in the room. As they conversed with each other, Ashley looked at me and said in a hushed tone, “My daughter and son were premature, and I would like to talk about it.” In social science research, we hardly ever have people ask to be interviewed, but she and I exchanged contact information. The plan was to let her take the lead in contacting me. I suggested she call me when she was ready to talk about the births of her children.

Ultimately, that conversation with Ashley would help to alter the shape of this book. Her story, as we will see, exemplifies a common problem. Black women are more likely than any other women in the United States to experience premature births, and to have low-birthweight infants. This book, in part spurred by that fateful conversation
with Ashley, undertakes a historically grounded discussion of this phenomenon. Ashley’s story is one of the many I collected during seven years of research that have culminated in this book. I argue that some pregnant Black women, like Ashley, experience medical encounters reminiscent of racist medical practices and beliefs that have persisted from the 1700s. My attempts to understand the historical roots of those experiences took me to medical journals, historians’ accounts, and other sources ranging from the 1700s to the twenty-first century. Using the afterlife of slavery framework as a critical lens to situate medical professionals’ practices, this book explores how Black women’s prenatal care, labor, birth, and treatment in medical environments, are extensions of eighteenth-, nineteenth-, and twentieth-century racial thinking. My analysis shows that despite the determined efforts of medical personnel, of the staff of agencies working to reduce adverse birth outcomes, and of birthing and reproductive justice advocates, the power of race and racism cuts across the American class divide, producing racial disparities in infant mortality and prematurity rates that call into question the efficacy of the “technologies of saving” pursued by advocates of NICUs and the health education campaigns used by public health proponents.

After the talk at which I met Ashley, I was driving to the airport and heard a weather report on the radio: the waters of Lake Michigan were surging. My palms felt as wet as the lake from anxiety, sweaty as I considered the implications of now including women in my research on NICUs. How could I tell their stories about pregnancies and births in ways that did not reproduce “ethnoporn,” a term I use to describe sustained ethnographic descriptions of incidents weighted down by graphic detail? Concerns revolving around power dynamics and ethical relationships between researcher and informant have been taken up by feminist scholars for several decades, and these matters also preoccupied me not only as a researcher but as a Black mother, and as a technically premature birth myself (Stacey 1988; Oakley 2016).

It was not so much that I feared an ethical dilemma about the research, although I wondered what feelings might emerge as a result of women reliving the memories of their difficult pregnancies and the births of their children. Rather, I wanted to be mindful of the choices I made in sharing the women’s experiences, of the analytical pitfalls and incentives that sometimes accompany such research (González-Lopez
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For example, narrative data presented in talks and panel discussions, often with predominantly white audiences, sometimes introduce the risk of narrowly positioning Black women primarily as victims. Like literary scholar and author Roxane Gay (2017), who describes how her discussions of being raped might be the only thing that would make her memorable, I was concerned that women’s accounts of adverse pregnancies would be the only way in which they might be remembered.

After consultation with some of the women who participated in the project, I determined that there was no way to anesthetize women’s descriptions of pregnancies that ended up in premature birth. If the women were willing to disclose the trauma of their pregnancies, labors, and births, then I would not write around what happened or the feelings that surfaced. And, indeed, they were willing. Their narratives led me to see how Black women interpret their births and how some resisted the shroud of adverse outcomes. Many do this by finding comprehensive care and alternative birthing methods. Women shared their encounters, hoping that others might benefit. So, it is with great humility that I share their stories with you.

Two months after we met, Ashley called, and we agreed to connect in a phone interview a few weeks later. When we spoke that first time, hardly any niceties were exchanged; Ashley launched right into what happened during both of her pregnancies. The reason for the first premature birth, Ashley revealed, was that she had placenta previa, a condition in which a placenta partially or totally covers the opening in the mother’s cervix. The placenta, which provides oxygen and nutrients to the developing embryo and removes waste products from its blood, is attached to the uterine wall, from which the umbilical cord arises. In most pregnancies, the placenta attaches at the top or side of the uterus, but in Ashley’s case it was attached at the lower end of her uterus. Because placenta previa can cause severe bleeding before or during birth, care providers recommend that women who are diagnosed with this condition refrain from physical exertion for a portion of their pregnancy. Despite bed rest, it is still likely that these women will have to undergo a C-section.

Just after Ashley disclosed that she had given birth prematurely, there was a pause—she inhaled then exhaled. Her deep breath seemed to pro-
pel the energy she needed to continue her story. After the exhale, Ashley was calmer than before, as she described her pregnancy. After she found out she was pregnant, Ashley took a leave of absence from college, moved home with her parents, and began working at a part-time job. She also signed up for All Kids, an insurance program for low-income people, during her pregnancy.4

Ashley had an ultrasound during her first trimester, and everything seemed fine. But during her second trimester, Ashley began to sense that something was wrong; she just did not feel right. Her concern precipitated her request for an additional ultrasound, but she said her doctor told her, “No, we don’t want to give you another ultrasound because we don’t want to hurt the baby.” During that same visit, Ashley asked the doctor again, and he responded that she did not need one. Ashley recalled, “After that, I was afraid. I thought I was going to have a miscarriage.”

One weekend, when her parents were out of town, things took a turn for the worse. Ashley shared with me:

It was early in the morning. I was confused, scared, and bleeding. I went to the hospital and they put me on magnesium for hypertension so I wouldn’t have seizures.5 I was at a teaching hospital. The nurses wanted to put in the IV. But I was swollen, my hands looked like I was a drug addict. . . . The people [at the hospital] were talking to me, but I did not hear what they were saying. I finally only understood [what was happening] because my grandmother and my aunt—who were both medical professionals—RNs—came later and explained what was going on with me.

It was at this point that Ashley’s placenta previa had been diagnosed. In a brief departure from the story of her unexpected labor, Ashley then began to tell me about her aunt, who had been a midwife for ten or fifteen years. I think this was Ashley’s version of taking a small break because when she resumed talking about the birth, she began talking rapidly:

When I arrived at the hospital, they tried to keep me on bed rest most of the day. They had me on machines and kept a close watch. They were hoping that the bleeding would stop. But then Jamie’s heart rate dropped
and they performed an emergency C-section. Jamie was born at twenty-six weeks and weighed one pound and eight ounces. She received a steroid shot to help with lung development, and then they took her to the incubator in the neonatal intensive care unit. I was in the hospital for about three days. Jamie was in the hospital from January 10 to March 6.

It is January 9, I thought to myself. At that moment, I realized we were having our conversation just one day before the anniversary of Jamie’s arrival. Worried, I wondered if it was too difficult to continue the conversation. Should I offer to end it? I asked, but Ashley said she wanted to continue, although just after sharing with me the details of her admission to the emergency room, there was silence on the phone. I broke it. “Ashley, how did they treat you and Jamie in the NICU?” Ashley responded, stating, “They treated Jamie fine. The NICU care was good.” Her response was not entirely accurate because later during our conversation, Ashley shared two disturbing incidents. First, on one of her daily visits Ashley arrived at the NICU to find that the tape used to hold down the nasal cannula inserted into Jamie’s nose had been taken off. The removal of the tape had pulled off some of the skin from Jamie’s upper lip. Ashley mentioned this to the nurse and requested they be more careful, which, Ashley felt, caused the nurse to be annoyed with her. The nurse’s annoyance intimidated Ashley, which in turn, she said, made her feel that some harm or neglect might befall Jamie.

Then there was the time when a nurse, who had not seen Ashley, put her own photo over Jamie’s isolette, or incubator. To Ashley, it was both infuriating and humiliating. It was infuriating because the nurse felt entitled to express her attachment to Jamie, which was disrespectful to Ashley, as Jamie’s mother. At the same time, it was also humiliating because Ashley said she was afraid to confront the nurse, though she wanted to do so, but feared there might be some retaliation against Jamie.

I later asked the question again, trying to ascertain if Ashley thought she was treated differently because she received All Kids, since receiving Medicaid or assistance from any public insurance program often “is sufficient to establish that a woman is ‘at social risk’” (Bridges 2011, 57). I also asked all women and the fathers whether they felt they and their children were treated differently due to race. Ashley responded, “I
personally don’t think they cared about me.” Even though she had some college education, Ashely admitted that she lacked knowledge about prenatal issues. So, when she asked questions, she doubted herself a little bit. When the medical staff spoke they “spewed out words,” which led to her feeling somewhat inept. Ashley believed that her care was compromised by the fact that she was young and the assumptions that the staff made about her education and economic status. These issues, combined with her race, led to medical professionals treating her dismissively. It did not matter if the medical professionals were Black or white, because Ashely’s providers were both. One of the points here is that as a cultural system, medical racism can be enacted by people of any racial or ethnic background; what matters more is who is being acted upon, and who suffers the consequences.

It should not be difficult to see how Ashely might connect the medical staff’s unwillingness to give her the second ultrasound, being dismissive of her concerns, and even the nurse taking the liberty of posting her own picture above Ashely’s baby’s isolette as manifestations of the intersection of race and class. Indeed, she surmised, “I think they looked at me as just another young Black girl receiving aid. And, that is why I did not get the second ultrasound. If I had, maybe they would have been able to catch the placenta previa.”

While this may not seem relevant to the discussion of Ashely’s treatment, the point she made was that she had not received the appropriate care. She felt that her race combined with her age and the fact that she received assistance meant that the medical staff considered it unnecessary to treat her with respect or take the time to explain what was going on in a way she was able to comprehend. Ashely’s summation suggests that when age and race intersect with type of insurance, that combination comes to stand in for one’s class and one’s ability to synthesize medical information, and these things together can influence how a person is treated. Preconceived ideas about Black women and public assistance certainly circulate in the popular realm and in the medical profession. Notably, receipt of public assistance is not necessarily indicative of a lack of education or lack of health knowledge. Nonetheless, poor women and women of color are often viewed with contempt by medical professionals and are seen as having “unruly bodies” (Bridges 2011, 16) and are easily disregarded.
What if the problem is age? It may seem easy to attribute Ashley’s situation to her youth; she was, after all, just nineteen. One might presume that her age made her less capable of negotiating with medical providers. One might also conclude that access to resources and private insurance offer protections against racial stereotyping or mistreatment. But, as the stories in this book will show, the questions, concerns, and uncertainties Ashley had about her treatment by doctors were similar to what other Black women of all ages experienced as well.

* * *

As she spoke, Ashley tacked back and forth in time, recalling different incidents. Sometimes it was difficult to follow her narrative. Her storytelling method illustrated the anxiety Ashley felt because she sensed there was a problem with her pregnancy but was dismissed by the doctor when she suggested another ultrasound. She expressed confusion about why she was bleeding but not being fully informed by medical personnel what was happening to her body. What may have been useful was for Ashley to have support, someone to serve as a mediator between her and the medical professionals—a person to advocate for her and on her behalf, as well as to be a witness during her medical encounters. Although her grandmother and aunt could have served that purpose, they did not live nearby.

Ashley’s story offers insight into the sometimes complicated relationship that Black women have with medical professionals with regard to reproduction, and specifically with regard to pregnancy and childbirth. She is one of the many African American women who have given birth prematurely in the United States and whose reproductive lives are often conveyed in terms of statistical data. Black women are more likely to die in pregnancy or childbirth, at a rate of three to four times that of white women (Maron 2015); according to the March of Dimes (2011), Black women in the United States are two times more likely to give birth prematurely than any other group of women. Ashley’s reproductive outcome is thus common among Black women who, regardless of class, have higher rates of premature births and low-birth-weight infants (Mullings and Wali 2001).

Among the range of health concerns Black women face during pregnancy, childbearing, and after birth are inadequate receipt of prenatal
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care, the prevalence of preterm birth, fetal mortality, restricted fetal growth, and maternal mortality. All these problems vary by maternal race/ethnicity (Bryant et al. 2010). Similar disparities exist among Native American women. Consider, for example, the work of sociologist Barbara Gurr (2015), whose scholarship is considered to be the first analysis of Native American women’s reproductive health care. At the time Gurr conducted her research, she found that the infant mortality rate was 28 percent higher among Native women than for all other US groups combined. Legacies of racism, gender, and class inequities also help to explain some of the obstetric violence toward and neglectful maternal experiences of Mexican women (Dixon 2015; Smith-Oka 2013), although racial categories in Latin America are typically organized in relation to ancestry and socioeconomic status, and racism is articulated differently than in the United States.

This book explores how medical racism—that is, the ideas and practices that perpetuate racial hierarchies and compromise one’s health or facilitate vulnerability to premature illness or death—influences medical encounters in the United States, particularly as it relates to Black women’s reproduction. It argues that Black women’s pregnancies and premature births are important sites of analysis to help us to understand medical racism.

Black women’s poor reproductive outcomes are often seen as a woman’s personal failure. For example, Black women’s adverse birth outcomes are typically discussed in terms of what the women do, such as drinking alcohol, smoking, and having less than optimal eating habits that lead to obesity and hypertension (Florido 2014). In other instances, their low earnings or their age is the focus of blame (Shamus 2016). They may be seen to be at risk based on the presumption that they are “single,” when in fact they have a partner—but are unmarried. Whatever the circumstance, Black women become wedged between embodying risk and being the targets of intervention.

Articles in the popular press tend to point out risk factors related to premature birth and birth outcomes by focusing on women who live under the most socioeconomically compromised circumstances: with poor prospects for employment and often facing health challenges such as diabetes and high blood pressure, along with other negative social determinants (see Braverman 2008). Combined, these characteristics
make Black women the foci of behavioral and public health education interventions. To be sure, these are factors that should not be dismissed. But that was not Ashley’s story line. Nor was it the story line of any other woman interviewed for this book.

What makes this book unique is that it centers on women whose social location—through their attainment of higher education and professional status—complicates common presumptions about who “carries” the risk factors leading to adverse birth outcomes. In this book, it is Black women—and those who are professional and college educated—who are central. Importantly, they too give birth prematurely at higher rates than white women with the least amount of education.

Additionally, this book is distinctive because discussions of premature birth generally privilege the infant and treatments used to address issues of fetal viability or underdevelopment. Here the focus is on mothers, placing Black women at the center of an analysis of reproduction. This approach is acutely important because the rise of reproductive technology has tended to decenter or displace women. Because of the degree to which technology mediates reproduction, much of the research has made technology the object of reproductive investigation. For instance, many scholars view surrogacy as a form of assisted reproductive technology (ART) that reduces women to rentable wombs (Twine 2011). Other feminist scholars of reproduction have noted—with alarm—that the rise of fetal protections, fetal surgeries, and ARTs and the dismantling of support for access to reproductive health care has led to the diminished importance of women (Casper 1998; Petchesky 2003; Ross and Solinger 2017).

Finally, this book does what anthropologist Leith Mullings suggests in her important article “Interrogating Racism: Toward an Antiracist Anthropology” (2005a). It goes beyond discussions of the socially constructed nature of race and attends to how racism in practice, a fundamental element of the social structure, is captured in women’s impression of medical encounters. It takes a different tack than sociologist John Hoberman’s book Black and Blue: The Origins and Consequences of Medical Racism (2012). Whereas Hoberman describes what doctors think about racial difference and how those differences play out in treatment, this book excavates women’s sense of racism during medical encounters. Consequently, this book is inspired by critical medical anthropol-
ogy, which anthropologist Hans Baer defines as that which “aspires to merge theory and praxis in [a] desire to promote experiential health as opposed to the functional health associated with contemporary political economics around the world” (1990, 1011). Because it appraises experiences rather than extrapolating data in the way that epidemiology does, this book offers a critical voice to the medicalization of pregnancy (Scheper-Hughes and Lock 1987).

This book draws on ethnographic interviews with nearly fifty people, including professional Black women (and three fathers), as well as doctors, nurses, March of Dimes administrators, and birth justice advocates, with the goal of examining pregnancy, prematurity, and NICUs as sites through which medical racism can be understood. Those narratives place this project in the tradition of Black feminist thought in the United States, as this research focuses on Black women to understand everyday life. As used here, a Black feminist approach resists the erasure of Black women’s lives and recognizes their experiences as sources of knowledge production. It takes seriously the credibility of Black women’s interpretive lens and privileges their feelings and analysis of the world, in this case of medical encounters (Collins 1991; Mullings 2000). As Lorde (1984) and Anzaldúa (1987) remind us, the details of the everyday and the particularities of lay knowledge stimulate an understanding of and ability to dismantle power.

Feminist inquiry into reproduction in the United States has tended to focus on the development and/or consequences of reproductive technology (see, for example, Casper 1998; Rapp 1999; L. M. Morgan 2009). Some scholars have conducted provocative investigations of nation building through reproductive processes (see Andaya 2014; Kanaaneh 2002). Other feminist anthropologists have unpacked the confluence of reproduction and race or race-making, which has been particularly insightful. For example, anthropologist Elizabeth F. S. Roberts’s (2012) ethnography of assisted reproduction in Ecuador reveals the relationship between science, religion, and race, emphasizing how race—whiteness in particular—is achieved through the types of medical care received. A second example is Daisy Deomampo’s (2016) research on surrogacy in India. Delving into how race is formed through instruments of the state and medical practices, Deomampo shows how ideas of race are articulated in the transactional process of egg donation for surrogacy and
further mediated through medical professionals and the state. Although race is increasingly at the center of reproductive scholarship, a limited number of anthropological texts explore reproduction and race in the United States—and too few lift up Black women’s reproductive lives.

In addition to being grounded in a Black feminist approach, this book is rooted in a Black feminist praxis by virtue of its citational politics (Ahmed 2017; Bolles 2013). This is a politics that insists on replicating knowledge about the subject of reproduction, prenatal care, and giving birth—as much as possible—from the corpus of work developed by women of color in general and Black women in particular. So, while this work builds on the robust tradition of feminist anthropological scholarship that has placed reproduction at the center of social theory (Ginsburg and Rapp 1995; Colen 1995) and is ideologically, theoretically, and politically aligned with that work, I have also placed emphasis on citing women of color.

Four US-based feminist scholars of reproduction and medical anthropology have especially influenced this book. Legal scholar Dorothy Roberts; anthropologists Leith Mullings and Alaka Wali; and legal scholar and anthropologist Khiara Bridges have each shed light on the racial aspects of reproduction. Respectively, they explore how law and policy seek to interrupt Black women’s reproduction, how low birth weight and infant mortality occur in the context of social stress and racism, and the political economy of reproduction.

In Killing the Black Body: Race, Reproduction and the Meaning of Liberty (1997), Dorothy E. Roberts considers the linkage between reproduction and racial inequality, drawing out how Black women’s reproduction has been regulated, which in turn has shaped what reproductive liberty means in the United States. Using historical and legal documents, Roberts explains how racial inequality has sabotaged, indeed destroyed, the idea of reproductive liberty on the backs of Black women.

The rich analysis Leith Mullings and Alaka Wali provide in Stress and Resilience: The Social Context of Reproduction in Central Harlem (2001) is based on an investigation of factors that lead to Black women’s higher rates of preterm birth and low-birth-weight infants. These scholars analyze a cross section of women’s experiences to understand what kinds of stresses impact their reproduction (such as housing fragility, unemployment, and work-related stress). Mullings and Wali also identify the
strategies that Black women deploy in the face of challenges related to their pregnancies and other forms of social reproduction.

More recently, in *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (2011), Khiara Bridges has explored the medical practices that racialize pregnant women living in New York City who are receiving Medicaid and use a public hospital for prenatal care. What Bridges describes in her analysis of women's medical interactions during pregnancy resonates with some of the incidents described by the women featured in this book. However, another group of women are also important in this book, namely, birth workers. Examining Black women's encounters of medical racism with medical professionals is another way of understanding biopolitics—the authoritative practice of intervention (Foucault 1997)—and can ultimately lead us to investigate how women resist that power. Therefore, by exploring what it means for Black women's reproduction to be abridged or neglected by medical professionals, this book also investigates the role played by reproductive care providers and advocates. Thus, the book asks, what are the ways in which pregnancy, labor, birthing, and having a premature infant in the NICU intersect with articulations of medical racism, and what strategies are used to address these problems?

Importantly, the difference in rates of prematurity by race in the United States has held strong since the time of enslavement. Thus, it is also useful to ask, how can historical references help us to understand how Black women are cared for and treated during medical interactions today? What form does contestation against the power of medical professionals take in stemming the tide of premature births among Black women?

What of women who do not have encounters that are characterized as medical racism? Do they confound the questions posed here? This book does not shy away from examples of women who maintain they have not had to contend with the same sort of racist practices in their medical encounters that Ashley confronted. In fact, it attempts to depict a range of circumstances experienced by Black women who were pregnant and gave birth. Even when women have positive encounters, they are giving birth in an anti-Black society, one that has continued to treat Black people with disdain, and they are experiencing their pregnancies and labor in a time that is the afterlife of slavery.
In the Afterlife of Slavery

This book offers a critical analysis of Black women’s pregnancy and premature birth, arguing that ideas about Black women that have historically circulated in the medical field must be understood as an extension of what Saidiya Hartman calls the afterlife of slavery. More specifically, prematurity, the most common cause of infant mortality, is an expression of this afterlife of slavery, interpretable through history. Hartman defines the afterlife of slavery this way:

Slavery had established a measure of man and a ranking of life and worth that has yet to be undone. If slavery persists as an issue in the political life of Black America, it is not because of an antiquarian obsession with bygone days or the burden of a too long memory, but because Black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery—skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment. I am the afterlife of slavery. (2007, 6)

I take Hartman’s definition of the afterlife of slavery not only as an impetus to connect the past to present issues but also as a form of situatedness. She identifies her position as a Black professional woman who feels the reverberation of enslavement, thus elucidating the broad reach and impact of the afterlife of slavery. The afterlife of slavery is a critical framework that makes it possible to talk about the continuation of racism in the medical management of Black women’s reproduction. The precarities of chattel slavery continue to impose on the conditions of Black life. Whereas reproduction has been invigorated by past racial hierarchies, the dystopian past is not just the past. The dystopian past inhabits present practices, including the practice of medicine.

Across a number of disciplines, rich scholarship explores antiblack racism through the afterlife of slavery concept to theorize how racial hierarchies have been and continue to be replenished. Among the contributions this scholarship makes is offering a way to think about the continuity of white supremacy; it does not decouple Black people’s contemporary lives from earlier periods, and it advances a critical method-
ology that facilitates a mode of inquiry that brings the past and present closer together. Cumulatively, this body of work offers a radical reading of current issues as they relate to historical sources.

Both racism and slavery in the United States have facilitated a reproductive dystopia in which almost all aspects of reproduction idealize whiteness. From breastfeeding to the fragility of uteruses, the pretense of perfection and importance has been legitimated through white womanhood (Schiebinger 2004). Additionally, in obstetric medicine, physicians have increasingly rebuffed women’s sense about their bodies, relying less on patient narratives in diagnosing disease and more on physical examinations (Schwartz 2006, 129). These changes in medical practice have positioned women differentially: whereas white women’s reproduction has been depicted in terms of chastity, enslaved women’s reproduction was generally viewed as evidence of promiscuity and lasciviousness or as necessary for racial capital (J. L. Morgan 2004). As medicine garnered greater acceptance, slaveholders relied on physicians to determine women’s reproductive status, harnessing medical treatment and diagnosis to the racial calculus identified by Hartman. The echoes of this racial calculus influenced the shift away from women’s narrative and feelings in diagnosis, a shift detected in current medical interactions, as is evident in Black women’s recollections of their birth experiences.

The afterlife of slavery, which makes connections between the present, the history of chattel slavery, and after slavery, draws from archival sources—broadly defined—that following Dorothy E. Roberts are “keyed specifically to our contemporary neoliberal and, it is implied, seemingly postracial reproductive landscape” (Weinbaum 2013, 50). Indeed, methodologically, this book stems from questions about what happens if ideas about the prenatal body, laboring, and birth outcomes are put into conversation with archival sources of transatlantic slavery and its afterlife. This book contends that Black women’s higher rates of premature birth are an expression of the afterlife of slavery, interpretable through documents such as medical texts, reports, pamphlets, narratives, and historians’ accounts of pregnancy and birthing.

Conceptually, the afterlife is not simply a consequential expression of inheritable trauma. In other words, I am not arguing that the afterlife of slavery has resulted in an epigenetic phenomenon (although it may). Instead, I argue that one way Black women’s prenatal experience, preg-
nancy, and birthing can be understood is as an extension of tropes, practices, and beliefs that can be traced back to antebellum and postbellum periods. What we see is that racism is continuously recalibrated—a racism that is a reinterpretation of enduring processes of slavery. In many ways, positioning biopolitics in this way, shuttling between the present and the past, shows, as Hartman notes, that slavery’s imprint is demonstrated in all sectors of society and has resonances in the contemporary moment.

My line of inquiry has some resonance with anthropologist Lisa Stevenson’s (2014) work, which examines the colonial bureaucracy that focused on improving the lives of Inuit in the Canadian Arctic. Stevenson draws on historical records to examine the influence of approaches to addressing two epidemics, tuberculosis and suicide, and finds that the texture of care and saving is recalibrated. Care, which Stevenson argues is a product of colonialism, is a liberal instantiation of the state’s interest in making citizens live. However, the liberal instantiation of the state’s approach to facilitating life, and presumably well-being, I argue, is much less stable and less valued relative to Black women.

Decolonized Methodology

One of the most important research principles I embrace as a feminist ethnographer is to connect my work to broader movements. In this case I wondered, “How might this project speak to or be informed by a reproductive justice framework?” Reproductive justice exists when all people have the economic, social, and political power and resources to make healthy decisions about their lives. It includes the right to have or not have children and focuses on personal bodily autonomy and living in safe and sustainable communities (Ross and Solinger 2017).

Taking up Indigenous education scholar Linda Tuhiwai Smith’s (2012) observation that many researchers and academics assume that our research will be beneficial, I intentionally sought out a community of people active in the reproductive justice movement to help me do more than deconstruct prematurity. I wanted the research to be useful. Participatory-action research seemed to be one logical methodological approach; however, I saw no obvious action in which people could participate as a result of my inquiry. One early attempt to collaborate with
a reproductive justice organization in Louisiana, where I conducted my first NICU observation, did not pan out. Initial interest waxed and then waned because the organization had to mobilize against proposed legislation mandating that abortion providers be affiliated with a hospital. At the time, organizing against the nationwide attack on access to reproductive services took precedence over doing work with a researcher.

Still committed to actualizing some form of feminist practice and choosing to be held accountable beyond the institutional review board, I invited a group of reproductive justice workers to join a reproductive justice interlocutor team. This was a team of people working in various realms of reproductive justice who were in dialogue with me from the beginning of the project. The four women who agreed to be part of this research endeavor are Toni Bond-Leonard, Andrea Queeley, Lynn Roberts, and Andrea B. Williams.

Toni Bond-Leonard is the cofounder and former president of Black Women for Reproductive Justice. When we met, Toni was board president of the National Network of Abortion Funds (NNAF), and I worked with her on NNAF’s strategic plan. Toni has two decades of experience in reproductive activism and has parlayed that expertise into a set of concerns centered on theology. She was also one of the women who created the term “reproductive justice” and has been active in the reproductive justice movement for more than twenty years. Toni helped me think through the ethical positioning of decentering the NICU.

Andrea Queeley is both an activist and a scholar, whose work examines African diasporic subject formation, migration, and the negotiation of globalized structural inequalities. Andrea worked with me to shape the theoretical direction this work eventually took.

Lynn Roberts is often referred to as the “godmother” of the reproductive justice movement. One of the original members of SisterSong—a women of color reproductive justice collective11—her research lies in the areas of adolescent and women’s health, violence prevention, community organizing and development, and health disparities. Lynn and I met regularly and discussed the interviews and emergent analyses.

Finally, Andrea B. Williams is a lawyer who manages the ReConnect project, a leadership training program for formerly incarcerated women at the Correctional Association of New York (CA). Before joining the CA, she was public policy coordinator at the HIV Law Project, where
she managed the Center for Women’s Organizing, an advocacy training program for women living with HIV and AIDS. Working with formerly incarcerated women to advocate for change, the CA has worked to redress the shackling of pregnant incarcerated women when they go into labor. Andrea read several drafts of my work and provided innumerable sources that helped shape this project.

Some members of the team helped to frame interview questions, others read various drafts, and still others pointed me in the direction of resources. They also helped to discern how this work might be useful to the broader reproductive justice movement as it offers an analysis of a reproductive issue that had not, until recently, been center stage in the movement—birth justice. The greatest gift they bestowed was in allowing me to draw on their vast knowledge—the knowledge of four Black feminists doing, or concerned about, reproductive justice work.

In addition to these four interlocutors, forty-nine other people participated in this project. This included seventeen parents, fourteen of whom were mothers and three of whom were fathers. The questions to parents centered on the content of their interactions with medical professionals during their pregnancies, asking them to recall their birth stories and how race factored into their medical treatment and hospitalizations. Of the seventeen parents, all but three identified as Black. Two were Filipina, and one was white. Between them, the parents had seventeen children admitted to an NICU, although several parents had other children as well. Two of the infants had a congenital illness. Nine of the infants were born at or before twenty-eight weeks, making them very preterm. Five of the infants were born between thirty and thirty-seven weeks, making them moderate to late preterm, and three infants were born at term, or forty weeks’ gestation.

Ten birth workers participated, including three midwives, three doulas, and four reproductive justice advocates. All of the birth workers but one identified as Black; the other worker was white. With this group, I was interested in how they viewed the issue of prematurity and the link between medical racism and adverse birth outcomes. Conversations also centered on the value they saw in returning to traditional childbirth as a strategy to arrest Black women’s unfavorable birth outcomes.

Among the seventeen hospital-based medical personnel there were seven neonatologists or residents and one retired obstetrician, five of
whom were white and three of whom were Black. Among the doctors three were men, three were women, and one was gender nonconforming. The obstetrician was a Black woman. Eight nurses participated (two were labor and delivery nurses, and the others were NICU nurses), as well as one hospital-based social worker. Of the nurses, four were Black and four were white; the social worker also was white.

I spent time with and interviewed five current or former administrators/executives from the March of Dimes, all but one of whom were white. The questions posed to both medical professionals and March of Dimes staff explored how they viewed NICU technology, what role they thought technology played in addressing premature births, and how they understood race with respect to premature birth.

The ways in which I came to meet the people interviewed varied. What some might say was opportunistic (Andaya 2014), I prefer to frame as serendipitous (Rivoal and Salazar 2013). In other words, unanticipated events opened up avenues for exploration and conversation with people who were not part of the original research project. As mentioned previously, originally I did not plan to interview parents. However, after Ashley initiated contact, I recruited other mothers on Facebook and through my social networks (convenience sampling) and was surprised when three fathers also agreed to be interviewed. Initially I thought the Facebook recruitment would lead me to people I already knew. As it turned out, I actually knew only five of the parents; all the others were unknown to me but made contact, wanting to be interviewed, and two were introduced by a mutual friend.

Attempts to broaden the range of parents to include those who had different degrees of access to resources and who were not professionals involved distributing flyers to mothers in an Early Intervention Program (EIP) housed at a New York City nonprofit organization. In New York, the EIP is administered by the New York State Department of Health through the Bureau of Early Intervention. According to the department’s website, “The New York State EIP is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. EIP was created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA)” (New York State Department of Health n.d.). To be eligible for services, children must be under three years of age and have a confirmed disability or developmental delay, as defined
by the state, in one or more of the following areas: physical, cognitive, communication, social-emotional, and/or adaptive. Although I offered gift certificates as an incentive to be interviewed, no one from the EIP program contacted me. One might say that too was serendipity, since the project ultimately focused on professional Black women, who are generally overlooked in feminist reproductive scholarship.

Those who responded to my Facebook request were all professional women and men—some of whom introduced me to other people whose children had been born prematurely. Generally, I believe they responded more readily than those whose children were part of the EIP because their children were older. Children in the program are no more than three years of age, which is the maximum age to qualify for services. Of the parents who did contact me, their children ranged in age from seven months to thirty-five years. My guess is that those parents who did agree to be interviewed generally had more emotional distance from when their child had been born prematurely and thus found it easier to discuss.

Another example of serendipity was that three fathers wanted to discuss their children's premature birth. Even though this project is concerned with Black women's premature births and their opinions of NICUs, I did not limit participants to mothers, African Americans, or those whose children had been born prematurely. If parents wanted to discuss their pregnancy, labor, and birth, it seemed unnecessary, even callous, to reject them by constructing rules of engagement that upheld the falsity of an “ideal” research participant. All parents, except one lesbian who was married, were heterosexual. Two mothers used ART to achieve conception. All the parents had singletons who survived, except one parent who had a set of twins, one of whom did not survive. Parents lived in California, Florida, Illinois, the New York tristate area, North Carolina, Texas, or Washington, DC, although that is not necessarily where their children were born.

Among medical professionals, snowball sampling was the primary recruitment tool. One physician introduced me to another, and so on. Dr. Johannes, the first neonatologist I met, introduced me to the chief of his unit, who in turn introduced me to another neonatologist on his staff. Later meetings with neonatologists were facilitated by convenience sampling, with two colleagues putting me in touch with neonatologists
they knew. The same sampling processes occurred with nurses and the social worker.

The project took on new dimensions after I made a cold call simply to obtain information about the public health approach to premature birth, a serendipitous event. I found myself in dialogue with administrators at the March of Dimes, interviewing them over the course of a year at their offices in New York and Washington, DC, and via phone. Consequently, I broadened the scope of the project to examine how the largest nonprofit organization in the United States dedicated to addressing premature birth thinks through and addresses the racial disparity associated with prematurity.

Another unexpected turn in the project was the result of registering for a birthing justice conference. Serendipity led to meeting and interviewing birth justice workers. When I arrived, doulas, midwives, mothers, fathers, public health providers (some of whom were men), and advocates had gathered to discuss the importance of demedicalizing birth and linking reproduction to broader social issues such as criminalization and policing. From this conference, it immediately became clear that some birthing projects and radical birth workers were in fact critiquing the organization of medicine and how it perpetuates reproductive racial inequalities. I participated in doula meet-up groups and trainings for doulas and birth workers of color in New York and Washington, DC. The birth workers interviewed were from Florida, Georgia, New Jersey, New York, and New Mexico. At the end of the research, I entered a doula training program and supported my first client just four weeks after completing my training. As a reproductive justice advocate and activist working toward the abolition of medical racism in the care that many Black women receive, becoming a doula has been an important aspect of this research.

I must admit, though, that having interviewed this large number of people does not mean I have reached the highest level of knowledge about pregnancy, prematurity, and race. Nor have I exhausted the interpretive possibilities of women’s experiences with medical racism. There are always more stories to hear, more NICUs to visit, and more documents to read. There is always more to know. But I hope what has been learned underscores that we need to care and do more to increase the birth options that Black women can access.
Deterritorialized Ethnographic Inquiry

Traditional ethnographic research has been place-based, but I take the view that feminist ethnographic inquiry can transcend parochial methods of participant observation in one locale with one group. An alternative to more traditional ethnographic inquiry is deterritorialized ethnographic inquiry, which centers on an issue, not a place (Wies and Haldane 2015). As described earlier, at the beginning of the research I tried to work with a reproductive justice group. Then, in the middle of the project I attempted to locate a “site” at one NICU and was approved. Research at that hospital never got off the ground, however, due to major renovations, making it impossible to conduct observations. In the end, given what some of the doctors and nurses shared, it was best not to have been at only one site because the multiple locations afforded medical staff anonymity, particularly for personnel of color who were often the only Black doctor or nurse at a hospital. Rather than being anchored to one NICU, ethnographic observations took place at various hospitals. Attending nurses’ meetings afforded me an opportunity to see how labor and birth and neonatal nursing responsibilities were delegated. I interviewed all the neonatologists and the obstetrician in person and interviewed nurses on the phone and in person. These specialists lived and worked in Florida, Louisiana, Minnesota, the New York tristate area, New England, and Ohio. NICUs can benefit from anthropological research, “helping people recognize other interpretations of a space and experiences that might otherwise be overlooked” (Downey and Dumit 1997, 3).

Neonatologists and nurses took me on guided tours of NICUs where I observed neonates in their incubators. These visits provided a first-hand view of how technology was grafted onto babies’ bodies. They were sometimes challenging because every moment felt like a potential emergency that could be followed by a potential loss. It was disconcerting to think that death or a negative outcome, despite technological advancement, might await the neonates in the NICU.

Not knowing the potential consequence of a birth outcome is a crucial reason I chose not to recruit parents whose children were currently in an NICU as research participants. Their vulnerability was palpable; having previously worked at a battered women’s shelter, I was leery of
trying to disentangle the emotions of having a child in an NICU and talking about racism at the time of crisis. Indeed, I am convinced that talking to parents at that time would not have necessarily revealed any particularly illuminating insight into what racism felt like to them. In fact, how parents felt about and understood the racism they encountered may have been digested and expressed with greater clarity because time had passed. Additionally, centering the ethnographic work on a particular place was not necessary for uncovering Black women’s accounts and recollections of their meetings with medical professionals. In the end, descriptions of those medical encounters that involved racism had similar expressions. In other words, regardless of place and time, narratives of racism were experienced in very similar ways by women of different ages and whether they were pregnant twenty years ago or eight months ago.

Interdisciplinary literatures informed the research and spoke to the many ways in which I believed I could learn the “secrets” of a subject—one with which I (and often the public) have little familiarity (Franklin 2013). To learn about prematurity and to get at its emotional vocabulary, I engaged with reproductive studies literature; science and technology studies; television shows such as Boardwalk Empire, which features an opening segment in which a man walks through a world’s fair with infants on display in incubators; documentaries such as Unnatural Causes (Strain 2008); newspaper articles; fiction; and self-published books by mothers and fathers who chronicled what it was like having their children born prematurely and then admitted to the NICU (see, for example, Degl 2013; A. Stevenson 2010).

I also read books written for the siblings of NICU babies and manuals by doctors and nurses explaining prematurity and NICU care. Not one of the fifteen books was written for Black children or was about prematurely born Black infants. I conducted a search on Amazon for books about premature birth. Of the forty-five books with images of premature infants or parents, four had an image of a person who appeared to be other than white. I examined websites for hospitals that had NICU services. In sum, I just followed the “subject.” Inspired by anthropologist Rayna Rapp’s (1999) methodological strategy of following the “object” in her biotechnology research, which involved examining biotechnology in
labs and hospitals and was linked to the recruitment of research participants, I followed the subject of pregnancy, prematurity, and racism that women experienced. I did so through observation, trainings, interviews, the collection of participant narratives, and an investigation of both primary and secondary archival sources.

For me, a Black feminist approach to ethnography has always meant putting Black women’s voices front and center. Recollections and memory are fundamental to this project, which is why Black women’s words are at the center of this book. Some of their memories of medical encounters produce important knowledge about the experience of medical racism. That knowledge provides an emotional literacy that may be difficult to capture through other methods. It is through the braided research and analytical strategies, including face-to-face interaction, archival research, and “following the subject,” that this ethnography gets at the meaning of people’s experiences. In sharing Black women’s stories from their perspective, and understanding at an intimate level how they negotiate the world and explain the things that happen to them, this book accomplishes what anthropological inquiry does best: calling attention to new issues and making connections between underexplored aspects of questions that cannot be adequately understood through broader strategies such as epidemiology or public health campaigns. Indeed, as I show, the processes that produce statistics and public health messages are deeply enmeshed with race. Through my research, I discovered that it was as important to understand the ways in which race infiltrates these practices as it was to expose the human toll that racial discourse takes upon Black women’s lives. The statistics show starkly that Black women’s bodies and babies are profoundly at risk. Thus, it is Black women’s words that we must hear if we are to understand the meaning and impact of that risk.

And so, I repeat: women’s own words are a legitimate source for knowledge production. How cruel and ironic that I even need to write that sentence. Across all of the research conducted, I simply wanted to learn from Black women if and how race and racism were manifest in their dealings with their doctors and nurses during prenatal care and while their children were in the NICU. What better evidence than their own words and experiences?
The Chapters

The analysis takes shape through the investigatory approaches as well as the structure of the book. Investigating pregnancy, prematurity, and race required looking at the issues from different angles. The dominant angle is rooted in Black feminist epistemology and centers women’s medical interfaces during various stages of pregnancy and the birth process. Other angles include looking at NICU technology and prematurity from the perspective of medical professionals. I also needed to look at prematurity from another angle, from the interventionist, educational, and preventionist domains. Therefore, the book is divided into two parts. Part I engages the concept of the afterlife of slavery to analyze prenatal care, labor, birth, and NICU admission narratives in the context of the legacy of Black women’s treatment at the hands of antebellum slave owners and doctors. Part II turn the lens toward the three different approaches that seek to address prematurity.

Part I consists of three chapters that center on Black women, most of whom are professionals and all of whom have attained higher levels of education. Organized around their narratives, the first three chapters make connections between women’s encounters using archival and popular sources. Archival materials serve as both evidence and interpretive tools alongside other data collection strategies to show that race and racism in the United States are tethered to Black women’s medical interactions as artifacts of slavery during their pregnancy and labor and while their infants received care in the NICU.

Chapter 1, “Premature Predicaments,” begins with a passage from Harriet Jacobs's autobiographical narrative *Incidents in the Life of a Slave Girl* that signposts a series of questions about the definition and etiology (or causes) of prematurity. Race and racial science animated the discovery and definition of prematurity, which are described in the chapter. To demonstrate the persistence of premature births among Black women in the United States, I share four women’s narratives of pregnancy and birthing, one each in the nineteenth and twentieth centuries, and two in the twenty-first century. The focus of their prenatal and pregnancy care sits at the intersection of race and the medical management of their reproduction.

The second chapter, “Into the NICU,” opens the door to the space where premature infants are admitted. The dominant point here is that
the NICU is a space with multiple meanings and interpretive possibilities. This chapter explores the meaning of the NICU and focuses on how the NICU has been interpreted by three parents and three neonatologists. Typically, the NICU is understood as a space that attends to a premature infant's incomplete development, but based on parents' descriptions, other dynamics emerge. Through their stories and based on discussions with neonatologists, we find out the circumstances under which racial dynamics do and do not percolate in the NICU. This chapter explores some of the undercurrents that take place in the NICU that go beyond saving premature and congenitally ill infants.

Chapter 3, “Pregnancy and Prematurity in the Afterlife of Slavery,” offers a close reading of one woman’s pregnancy and labor to illustrate the medical treatment she received during this time and after giving birth. This chapter considers how medical practice and care are orchestrated against Black women’s interests. Making interpretive connections between one woman’s experience and primary sources from medical journals and historians’ accounts, this chapter demonstrates that earlier ideas about Black women and infants and about medical racism have migrated to the present in the form of diagnostic lapses.

Segueing to the second part of the book, I offer an interlude by describing a birth in which I participated. Then, part II chronicles three particular strategies of addressing premature birth, from the technological intervention approach to the public health perspective, which centers on public education and raising awareness through the use of numbers. I conclude with the prevention approaches that have been utilized by radical birth workers.

Chapter 4, “Saving the Babies,” examines several interventions used to address premature birth. In this chapter I bring together a range of documents and sources to create an archive of “baby-saving” strategies from the early twentieth century to the present. The strategies point to efforts to decrease prematurity and infant and maternal mortality through program implementation, policy, and technological development. Below the surface of saving intervention strategies, the archive reveals that a racial calculus—sometimes political, sometimes not—has thwarted the ability to successfully address birthing outcomes of Black women and infants. Essentially this chapter explores the tension between the state’s long-standing interest in addressing infant, child, and maternal mortal-
ity and how that interest has lacked strength when viewed through a critical race lens. While in earlier chapters the narratives of mothers’ and doctors’ voices took center stage, in this one we will hear from NICU nurses and administrators from the March of Dimes to reveal some of the apprehensions they have concerning the idea of saving.

Chapter 5, “Narrowing the Gap of Black Women’s Burden,” examines a public health approach to addressing the racial disparity of prematurity. Historically, the March of Dimes has developed public education campaigns to address child-related health issues, and race has always factored into those health concerns. While the organization has been successful in raising awareness of public health issues, including premature birth, this chapter examines how the use of data to illustrate the scope of premature birth, as an intervention, also raises questions about the use of data to address racial disparity.

The final chapter is “Radical Black Birth Workers,” whose emphasis is on the preventive approaches that Black (and other) women embrace, specifically doulas, midwives, birth workers, and advocates. They engage in birth work not only as care and service providers but also as part of a political project to stem Black women’s high rates of adverse birth outcomes and to transform the medical-industrial complex. In this chapter, interviews with birth and reproductive justice advocates point to the role that community-based midwives and doulas play as they seek to establish humane birthing practices geared to all women in general, but Black women in particular.

The conclusion reflects on the themes raised in the chapters. This book elucidates how racism is experienced by Black women at a time when Black maternal and infant mortality and morbidity are a major concern in the United States. Because each chapter highlights various aspects of the persistently high rates of adverse birth outcomes and the ways that race and medical racism have disrupted Black women’s and men’s reproduction, the conclusion highlights some approaches that may deal with the problem. Importantly, it is through the care practices of radical Black birth workers and expanding care and birth options that we find a potent response to medical racism and effective work to attain outcomes that are more in alignment with the goals of reproductive justice.